

Information Systems Security Access Agreement: VISITS

This form grants authorization to individuals to access the Virginia Infant Screening and Infant Tracking System (VISITS) database. The database owner, the Division of Child and Adolescent Health (DCAH) of the Virginia Department of Health (VDH), must grant specific authorization to those who wish to access the database system. Without this authorization, no individual has any general authority to view, insert, delete, or update VISITS data. The criteria used to determine access should be based on a minimum privilege needed by the individual to perform their job duties.

Access has been granted to me by VDH as a necessary privilege in order to perform my authorized job functions. As a user of the Department of Health information systems, I understand and agree to abide by the VISITS Security Policy and the following terms that govern my access to and use of the system. All logon IDs and passwords shall be safeguarded, and passwords shall not be revealed to others. I am prohibited from using or knowingly permitting use of any logon ID's and passwords for any purposes other than those required to perform my authorized job functions. I agree to change passwords immediately if they are compromised. I understand that I am responsible for all activities performed under my assigned logon ID. If the system is misused under my password, I am responsible.

I will not disclose any confidential, restricted or sensitive data to unauthorized persons. I will not disclose information regarding any access control mechanism of which I have knowledge.

I agree to abide by all applicable Federal, Commonwealth of Virginia and VDH agency policies, Procedures, and Standards that relate to the security of the VDH information systems and the data contained therein.

If I observe incidents of noncompliance with the terms of this agreement, I am responsible for reporting them to the information security officer and management of my employing agency as well as management of VDH.

I give consent to the monitoring of my activities on VDH information systems.

By signing this agreement, I hereby certify that I understand the preceding terms and provisions and that I accept the responsibility of adhering to the same. I further acknowledge that any infractions of this agreement will result in the termination of my access privileges. I have read and have had an opportunity to ask questions and obtain responses in order for me to understand the content of the DCAH document, *Information Systems: Security and Confidentiality Policies, Procedures, and Standards*.

Employee's Full Name: _____

Hospital Name: _____

Hospital Location (city): _____

Job Title: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Supervisor's Name (Printed): _____

Fax completed form to: 804-864-7721.

Mail original form to: Virginia Department of Health, James Madison Building, 109 Governor Street, 8th Floor, Richmond, VA 23219. ATTN: Division of Child and Adolescent Health/**VEHDIP** (if *Hearing Modules User*) or ATTN Division of Child and Adolescent Health/**VaCARES** (if *VaCARES Module User*).

VDH Use Only: Approved VISITS User Role: _____

Program Manager (Print): _____

Signature: _____ Date: _____